Willingness of women to test for HIV/AIDS: A case study of Zomba rural, Malawi

Priscilla Chimwele
Chancellor College
University of Malawi

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in masters' courses, specific skills courses, student grants and mentoring. The capacity building activities in EQUINET are integrated within the existing areas of work of the network or build cross cutting skills demanded across themes by institutions in the network. The papers and reports produced in these training activities are products that are used to support or target mentoring. This report has been produced within one of these capacity and skills building activities and is disseminated in this context. It is not a formal EQUINET discussion or policy paper.

Executive summary

A cross-sectional study using quantitative and qualitative methods was carried out in a few selected areas of Zomba rural. The study set out to explore the reasons why women do not go for VCT regardless of numerous campaigns on HIV testing. The main objectives of the study were to find out whether or not the women in the selected sample were willing to test, and to find out factors that influenced their decisions to go for a test or not to go. The study focused on women because they are the ones most affected by HIV/AIDS. Thus by knowing their status, women would take appropriate measures around prevention and treatment. A sample of 200 women was drawn using a systematic random sampling procedure. The study found out that most women from the sampled areas were willing to test for HIV, but that such factors as the views of other people, especially those important to the women in some way, and also ignorance, though to a lesser extent than the former, do play a part in whether the women go for an HIV test or not. It is therefore recommended that these factors be dealt with and cleared before women can be expected to willingly go and test.

1. Background

Malawi is a small sub-saharan country with a population of about 11 million people. According to the Human Development Report (UNDP. 2001a), almost half of Malawi's population (46%) is below the age of 15 years and about 4% is 65 years or older. Malawi is a socially diverse country, with various ethnic groups and religions with 80% of the population being Christian. The majority of Malawians live in the rural areas (Encarta Encyclopedia, 2004). Approximately 40% of households are female-headed and most of these households are poor.

The country has been highly affected by the HIV/AIDS epidemic. It is estimated that 14.1% of the population is living with HIV, a virus that causes AIDS (NAC, 2004). The epidemic has reached a crisis level since it was first diagnosed in May 1985, killing over 500,000 people by the year 2002. Evidence suggests that there are more women infected by HIV/AIDS than men. The HIV/AIDS prevalence among females in the age group (15-24 years) is reported to be four to six times higher than amongst males (NACP, 1999). There are also higher prevalence rates in the south than in the north and central regions (NAC, 2004)

The goal for the two-year plan for scaling up Counselling and Testing services is to test 250 000 patients coming to health facilities which have a CT site and to test 500 000 people who voluntarily want to know their status (MOH, 2004). Anti- retroviral drugs, a treatment which prolongs lives of those living with HIV/AIDS is now available. However people cannot access ARVs if they have not been tested for HIV/AIDS. Therefore it is important that people go for HIV counseling and testing in order to know their HIV status and where necessary access ARVs. In Malawi, Counselling and testing is defined as the process through which an individual is confidentially counselled and tested for HIV (MoH 2004).

Zomba district is situated in the southern region of Malawi and has an estimated population of 546, 661 people (NSO,2000). According to the HIV/AIDS situational analysis in 2004, it was reported that Zomba district had a total of 14 counselling and testing sites (MOH 2005). 8536 people were reported to have gone for counseling and

testing and 29.1% were tested positive in the year 2004. This positivity rate is relatively high as compared to the national prevalence rate which is estimated at 14.1%. Despite the high positivity rate, fewer women than men are known to be going for CT in Malawi (Nyirenda, 2005)-this is the case when we exclude PMTCT data.1[1] But since not all women access PMTCT services, it can be said that most of them are being missed (Makwiza et al, 2005). The present study, conducted in selected areas of Zomba rural, therefore set out to explore why most women do not go for CT regardless of the campaign encouraging people to go for CT.

2. Objectives and methods

The aim of this study was to find out whether or not women are willing to get tested for HIV/AIDS and to learn the factors that affect their willingness to go for testing.

The specific objectives of the study were to:

- find out if women are willing to go for HIV testing.
- identify factors that influence women to be willing/not to be willing to go for HIV testing.
- explore whether or not other people play a role in the women's decision to either go or not to go for a test.

2.1. Methodology

The study used quantitative and qualitative methods. This methodological triangulation was done in order to enhance the complementarity of the findings. The quantitative part of the study looked at the proportion of women that were willing to test and those that were not. The qualitative part of the study tried to gauge in their own words, the attitudes of the women in the selected sample towards getting an HIV test and why they felt this way. The qualitative approach was also used in interviewing counselors from the voluntary counseling and testing sites. Thus the study used questionnaires women as respondents, in-depth interviews with women and Key informant interviews with counsellors from CT sites.

2.2. Study site, sampling and respondents

The study was conducted in the rural areas of Zomba district. Using listings from the National Statistics Office in Zomba, a sample of 200 women from the selected rural areas of Ntanya and Buleya under T.A. Chikowi, Chingale and Thondwe under T.A. Mlumbe, Domasi under T.A. Malemia and Msondole under T.A. Kuntumanje was randomly and systematically selected. Using random selection, the women were picked from these listings before they were to be interviewed. Additional names were also picked as back-up in case any of the women on the original list was unable to participate in the study for whatever reason.

Under each of the four T.A.s, there was a selection of fifty subjects to have as equal representation as possible. The ages ranged from eighteen to sixty years for the selected sample frame.

1[1] When figures of women who access CT through PMTCT are added, more women than men access CT.

Key informant interviews were also conducted with counselors from voluntary counseling and testing sites. A total of three key informants were interviewed. The key informants were purposively selected.

2.3. Data collection and analysis

A questionnaire which included closed and open ended questions was administered to the sampled women from the four TAs. Question guides were used in the key informant interviews with the CT counsellors.

The primary data analysis tool used in the analysis of the data gathered in this study was SPSS for the questionnaires The frequencies and percentages acquired from this were then compared to see if there was any relation between what the women said they were willing to do, for instance test, and what they actually did, i.e. whether or not they had actually been for a test. From the other questions in the questionnaires, the women provided answers for why they felt or acted the way that they did. The frequencies and percentages for these responses were also analyzed and from these, conclusions were made.

The data that was collected through the semi-structured interviews with the counselors was primarily analyzed using a framework analysis where themes and sub themes were drawn out from the data. The responses -on why women do not go for testing -given by counsellors were compared to those given by the women.

3. Results

3.1. Respondent characteristics

The demographic characteristics of the women in the selected sample frame were looked into with the hope that the differences would, to some extent, have an impact/influence on their differences in the attitudes of the women to HIV testing.

The study comprised of 200 women between the age of eighteen and sixty (see results in *Table 1*).

Table 1: Age distribution of study sample

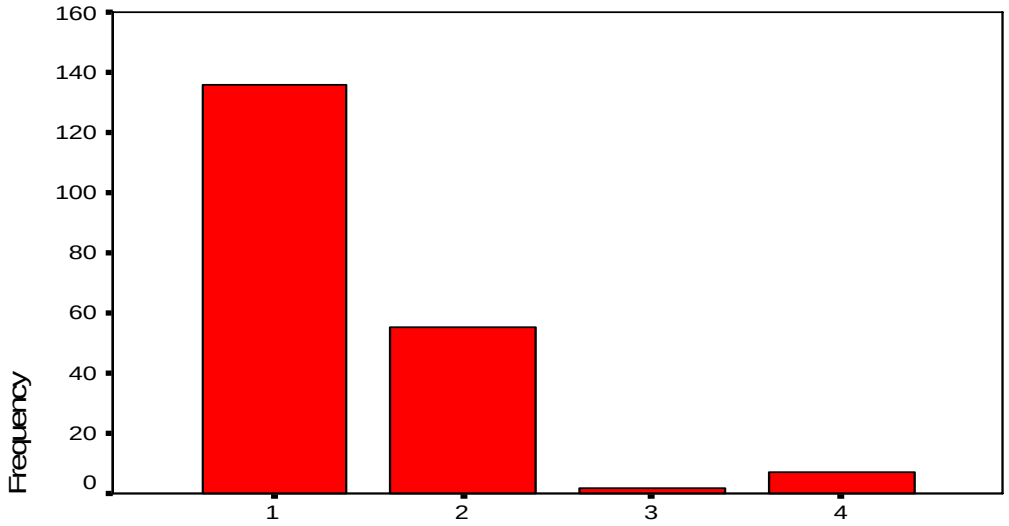
Age group	Frequency	Percent	Cumulative %
18-29	122	61.0	61.0
30-39	45	22.5	83.5
40 plus	33	16.5	100.0
Total	**200**	**100**	

The occupations of the women in the selected sample differed, although they were generally similar and could be cut down to either being a house-wife(63.5%), employed (7.0%) or a business woman (29.5%). Further enquiry into the businesses done by the women revealed that they were mostly petty businesses that were barely enough to sustain these women's livelihoods. The businesses included selling firewood, fruits

which they had picked from their trees or in other instances, frying tiny fish coated in flour and selling them at market places for very little money.

The education levels of the women in this study also differed (see table 3 below). Of the 200 women, 136, (68.0%) of them had gone only as far as primary school. But it should be noted that very few of these 136 women had actually gone through and finished primary school. Of the other women, 55 (27.5%), had been to secondary school, again, with very few of them finishing their studies at this level of education. Only two women had ever attended post-secondary education with seven women (3.5%) that had never attended any formal education (see figure 1 below for the summary of the women's education levels reached)

Figure 1: Education levels of rural women in four TAs of Zomba.



1= primary 2= secondary; 3= post secondary 4 = no schooling

The last Demographic characteristic that was looked at was the marital status of these women (as summarised in *Table 2*).

Table 2: Marital status of rural women in four TAs of Zomba.

Marital status	Frequency	Percent	Cumulative %
Never married	13	6.5	6.5
Married	140	70	76.5
Divorced	26	13	89.5
Separated	8	4.0	93.5
Widowed	13	6.5	100
Total	200	100	

3.2. Women's willingness to test for HIV

The first objective of this study was to find out whether or not the women were willing to get tested. The results showed that 38, (19.0 %) of the women in this sample had already been for a test. Amongst the remaining 162, 135 (67.5 %), said that they were willing to go for a test. The other 27, (13.5 %) of the women said that they were not willing to go for a test and that they would not get tested even if the services were offered to them.

Why women willing to be tested had not gone for testing: matching words and actions
While most women indicated willingness to test for HIV, very few of them 32 women (representing 16%) had actually gone for a test. These findings are similar to Mc Auliffe and Ntata (1994) study conducted across Malawi that focused on the youths and CT among other issues. In the present study, the subjects who said that they were willing to test but had not yet gone for CT were asked for the reasons behind their decisions. The women gave different reasons why they had not gone for testing despite showing their willingness to be tested (see *Table 3*).

Table 3: Reasons why women willing to go for CT had not gone for the test

Reason	Frequency	Percent	Cumulative %
No money	6	3.6	3.6
No need to test	55	32.7	36.3
Anxiety	22	13.1	49.4
Husband	6	3.6	53
Ignorance	6	3.6	56.6
Always busy	47	28	84.6
No specific reason	26	15.5	84.0
Total	**168**	**100**	**100**

As shown above, 55 women (representing 32.7%), had not gone for CT, despite expression of willingness to do so, because they were very confident that they would test HIV negative, and so saw no need to do so. Similar results were found in a study conducted at Chancellor College amongst undergraduate students (Nyirenda, 2004). There is therefore need to sensitise the women on why people need to go for CT; that there are advantages of going for CT even when one is tested HIV negative. In one interview in the present study, one of the women said that she felt that testing was specifically for those people who doubted themselves and thought that they could be positive. She was fairly certain of her negative status therefore saw no need to get tested for HIV.

Twenty two (13.1%) of the women who were willing to test said that they had not yet tested because they were scared. They said that they were afraid of being found HIV positive. They said however, that if the chance arose, they would get tested.
Forty seven women (28%) said that they were willing to test but could not get tested because they were always too busy and had no free time in which they could go to an HIV testing site. These women said that they had too much to do either at home, in their fields (especially in the rainy season), or at the market place and could not afford to take the time to go to centers where they could get tested; especially seeing that the centers are so far away from their places of residence. Six (3.6%) of the women specifically said

that they had not tested because the centers were too far away and they did not have the financial resources to get there.

This calls for the need to take CT services close to the people. This observation was also made after synthesis studies that looked at access to CT and ART in Malawi where it was found out that distance to CT sites was one of the major barriers to CT in Malawi (Makwiza et al, 2005).
Furthermore, women (15.5%) said that they were willing to test for HIV but could simply not be bothered to go and get tested. They gave no specific reason for their stand. They were neither too busy to go to the centers and get a test, nor were they too far away. They were also too confident in their HIV statuses and so could not be bothered to go for CT.

3.2.1. Not willing to be tested

The women who reported that they were not willing to be tested were asked why they did not want to be tested. The reasons for not willing to be tested were anxiety and no need to test because of their confidence in their negative statuses (see *Table 4*).

Table 4: Why some women were not willing to go for CT

Reason	Frequency	Percent	Cumulative %
Anxiety	11	42.3	42.3
No need to test	15	57.7	100
Other people	0	0	100
Total	**26**	**100**	

Twenty seven (13.5 %) women not willing to go for CT said that they would not get tested even if the chance arose. The study found that 11 of the women who were not willing to test felt that way because they were afraid of what the result would be. They felt that they were better off not knowing their status than knowing they were positive. All in all, their unwillingness to test was fuelled by their anxiety.

This finding was supported by a key informant interview with Frank Jumbe.2[3] He said through his experience with the women of the Thondwe area, he sometimes found it difficult to convince them to get tested because of their anxiety. He pointed out that this was one of the major reasons why most women had not been for a test. Most of them were simply afraid of the results and the implications of being found positive and would rather be at peace in their ignorance, than lose their peace with knowledge of their HIV positive status. One of the women indicated that if found HIV positive, she would commit suicide.3[4] This is mainly because most of the people in these areas equate being found positive to a death sentence. These women live with the notion that being HIV positive is the same as being dead.

2[3] Mr Frank Jumbe is a professional counsellor who deals with women in his community on AIDS related issues on a daily basis. He is based at a VCT centre in Thondwe, one of the study areas of this survey.
3[4] There have been incidents of people committing suicide because of their HIV positive status in Malawi. Recently, a woman killed her baby in Karonga district when she was told at the hospital that the baby was HIV positive. She attempted suicide herself before being apprehended by the police. She later died in custody.

The rest of the women who were not willing to get tested, (16 women) felt this way because they saw no need to go and get a test because they "knew" they were negative. Most of the women who said that were either above 40 years of age (in the 40 plus age group). They were also either widowed or unattached and claimed that they really did not see how they could get the virus because they were sexually inactive. These women had decided that they would not get tested, even if the chance arose. They had absolutely no knowledge of their statuses and were not even interested in finding out. One of the subjects said that she was too old and that HIV was a "young people's" issue such that the interview conducted with her was just a bother. This calls for further civic education concerning how HIV is transmitted as many people still equate HIV with sex. There is also a tendency to equate HIV with sexual promiscuity and not sexual intercourse per se amongst most Malawians (Makwiza, 2004; 2005 et al). Therefore, the emphasis on sexual promiscuity as 'the' mode of HIV transmission would also fuel stigma as those with the virus would be seen as promiscuous. This would hamper efforts aimed at encouraging people to access HIV/AIDS services such as CT.

3.3. The role of other people

The next objective of the study was to see whether or not other people play a role in the women's decision to go or not to go for a test. In this study, we found that 6 of the women, (3.0 % of the total sample), were willing to get a test, but could not do so because they had not gotten "permission" from their husbands to do so. Some said that they had not yet discussed it with their husbands and so could not just go ahead and test. Others had actually discussed it but their husbands had refused and so they had not tested. This scenario is common across Malawi where culture demands women to seek permission from their husbands before implementing most decisions including going for CT (NAC Newsletter, 2005).

In an interview with one of the counselors, it was found that this is usually the case. Some of the women had confided in him that they could not test because their husbands had strictly forbidden them to do so. He said that usually in such cases, the man had been, or was, promiscuous and knew that there was a very high probability that he was positive. He also knew therefore that if the woman, his wife, was to get a test, she would most likely be found positive. Therefore he prevents her from testing; an indirect way of running away from knowing his own status.4[5]

When the women were asked whether or not they would reveal their status to anyone if they were to be found positive, most of them said that they would i.e. 167 (83.5 % of the total sample). The rest of them said that they could not reveal their status if they were to be found positive because they were mostly afraid of the discrimination from people that they were sure would ensue. One of the women said that she could neither test nor, if found positive, could she reveal her status because she knew for sure that her husband would leave her.

In one of the areas that were studied, a woman who had been found positive and had revealed her status had completely lost all her friends. This woman had tested and

4[5] The counselor's views disregarded a situation where one in a couple can be found HIV negative despite the partner being HIV positive i.e. the scenario of discordant couples. Such scenarios are however very rare.

revealed her status to her friends who had in-turn revealed this to the community at large. This woman had since been side-lined and excluded in all community activities that took place, along with her husband. These people were, for instance, told at a community gathering by their chief, where they were supposed to get fertilizer coupons so that they increase their yields, that they would not get any because they had AIDS and were soon going to die so to entrust them with the coupons would be too costly to the chief, even though both he woman and her husband were still quite healthy and able to work. None of the other people at the gathering stood up for them or said anything in their favor or even helped them in any way.

Most of the women however said that they would reveal their results. Most of them said that they would reveal them to people who were close to them and they knew they could trust.

3.4. Ignorance

It was theorized that ignorance could be a factor in the women's unwillingness to test. After all, it is said that; *"what one does not know does not exist".* It is therefore quite difficult for the women to be willing to test if they do not know about the HIV/AIDS virus or about things associated with it. In a semi-structured interview with one of the counsellors met, she said that it was sometimes difficult for people to make informed decisions about what to do with the virus because of lack of sufficient information concerning the virus5[6].

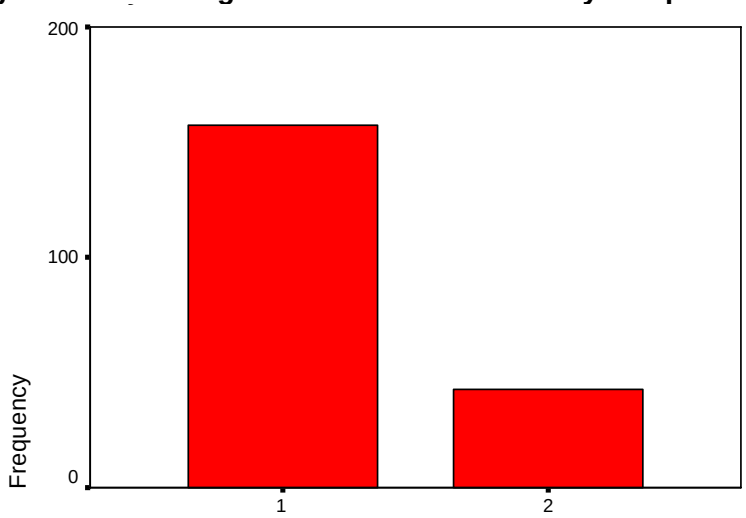
She said; "It is because people do not have enough information about the disease and other issues that are related to it that they can not make smart and informed decisions on their own, especially the women."

In the interviews with the women, they were asked some questions that would show their knowledge about the HIV/AIDS virus and some issues related to it. When they were asked about Anti-Retroviral (ARV's) and what they were, 157 of the women in the study, ie 78.5 % of the sample claimed that they had heard of them before and knew what they were. And the other 43 (21.5 % of the sample) said that they had no idea what they were and that they had never heard of them. Figure 2 shows these results.

In the follow-up question that asked the women what these ARVs are though, it was found that only 115 of the women had good knowledge of ARVs, (i.e. Medicine that helps strengthen the immunity systems of people infected with the virus and helps prolong their lives) (see *Table 5*).

5[6] A councillor, Mrs ZKC Chakale , based at ADL said this was one of the biggest problems in this Organization as well as the country at large. People do not have enough access to information on AIDS related issues.

Figure 2: Knowledge about ARVs in the study sample



1= yes 2 = no

Table 5: Knowledge about AIDS Treatment in the study sample

Response	Frequency	Percent	Cumulative %
AIDS cure	7	3.5	3.5
Prolongs life	115	57.5	61.0
Doctors	3	1.5	62.5
AIDS prevention	9	4.5	67.0
No idea	66	33.0	100.0
Total	**200**	**100**	

The other 66 (33.0 % of the sample) said that they either knew what ARVs are but that they could not explain, or that they really had no idea what they were. The other 19 could not explain clearly what they were but knew that they had something to do with the HIV/AIDS virus. Their responses varied from medicine that cures the virus, to a group of doctors that worked on the virus to medicine that prevents that contraction of the virus.

In a related question that asked the women if they knew how to access the ARVs, it was found that 64 women (32.0 % of the sample) said that they had no idea how they would access this treatment if they needed it, while the majority i.e., 132 women (66 % of the sample), said that they would either get the treatment from the local clinics or health centers or at the Zomba General Hospital. Table 10 below shows these results.

It should be noted however that most of these women were not completely sure that these were places that you could get the treatment from. They simply concluded that since ARVs are drugs, and that drugs are gotten from hospitals, therefore you can get ARVs from hospitals. Some 3 women (1.5 % of the sample) felt that they could buy the ARVs at a pharmacy of off the street if they needed them and one woman said that she would share the Antiretrovirals with a friend.

In another related set of questions that asked the women if they knew about the Prevention from Mother to Child Transmission facility (PMTCT). PMTCT is one of the

main ways through which women in the reproductive age group can access HIV testing. The findings showed that 128 (64 % of the sample) said that they had never heard of such a facility, while the other 72 (36 % of the sample said that they had heard of it before

When these women were asked if they would know where to get this facility if they needed it, the majority of them said that they would have no idea how to go about getting it (i.e. 103 women who constituted 51.5 % of the sample). 91 of the women (45.5 % of the sample) however, were well able to assess that the hospital would be the best place to try and get this facility. The other six however did not even bother trying to say where they would get the facility because they were sure that they could not afford it, therefore it made no difference whether they knew where they could get from or not (see *Table 6*).

Table 6: Access to a facility for Prevention of Parent to Child Transmission

Response	Frequency	Percent	Cumulative %
Local clinic	51	25.5	25.5
General hospital	40	20.0	45.5
Can't afford it	6	3.0	48.5
Don't know	103	51.5	100.0
Total	**200**	**100**	

4. Conclusions

In conclusion, this study has shown that the women of Zomba rural are willing to test but they face a great many barriers that they have to overcome before they can freely do so.

Perhaps the most effective way to get the women to test would be, especially for the anxious ones, to get the message that it is not the end for them if they are to be found positive, across. To let them know that there are many things that can be done for them that can help them live long healthy lives, even in their positive states. Also, for those who are over-confident, to also get the message across that it can happen to anyone, even them. And it is better to be safe than sorry.

As much as other people are important in our every day lives, these women also have to be told that it is their life that they are fighting for. If they feel something is wrong with their body, they should go ahead and get tested and not indefinitely wait on their husbands to make the decision for them to go and do so.

The messages on ARV treatment and the availability of such facilities as PMTCT should be well and clearly made known. But most important, access to these facilities should be available, even to the average Malawian. Many of the messages that we hear on AIDS are that it kills. Perhaps those on these treatments infected people should be made as loud as well. Many AIDS campaigns concentrate on the prevention of the virus. This is all good and well, but it perhaps should concentrate just as much on fighting the virus if you already have it. Because for many people in this nation, this is the battle they are fighting. Living with the virus, not preventing it.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

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- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
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- Monitoring health equity and supporting evidence led policy

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Training and Research Support Centre (TARSC)
47 Van Praagh Ave, Milton Park, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org